Washington Health Benefit Exchange
521 Capitol Way South
Olympia, Washington 98501

Application for Participation in the Washington Health Benefit Exchange

DATE

DRAFT version 2.0 for External Discussion

November 5, 2012

TABLE OF CONTENTS

SECTION I: INTRODUCTION

This Application specifies how a health insurance issuer can participate in the Washington Healthplanfinder, Washington's State Health Benefit Exchange (HBE).

The Application will provide information on the following:

- Certifying and recertifying a health plan to become a Qualified Health Plan (QHP) offered through the Exchange;
- Monitoring and compliance of QHPs;
- Decertifying a QHP;
- Special guidance for coverage of American Indian/Alaska Natives;
- Guidance on enrollment and billing;
- Guidance on participating in SHOP.

The Patient Protection and Affordable Care Act of 2010 (ACA) authorized the creation of state-based and administered Health Benefit Exchanges. The Washington State Legislature and Governor Gregoire established HBE and the Board by enacting Substitute Senate Bill 5445. HBE is governed by an eleven member Board consisting of eight voting Board members, a ninth member as the Chair who only votes in the case of a tie, plus two non-voting, ex-officio members, the Washington State Insurance Commissioner and the Administrator of the Washington State Health Care Authority.

Engrossed Second Substitute House Bill 2319 authorized the Board to govern the Exchange and to certify QHPs offered through the Exchange. On June 13, 2012, the Board adopted nineteen criteria to certify QHPs to be offered through Healthplanfinder.

HBE has been working closely with stakeholders, sovereign nations, and federal and state agencies, to ensure that Healthplanfinder will be ready to perform open enrollment of health insurance plans beginning October 1, 2013. Likely, 100,000 to 400,000 Washington residents could become insured in individual or Small Business Health Options Program (SHOP) plans purchased through Healthplanfinder.

The Washington State Office of the Insurance Commissioner (OIC) regulates health insurance issuers and health plans. HBE will not provide an issuer with guidance on achieving regulatory approval by the OIC. Throughout this document, however, HBE may refer issuers to the OIC's as the source of regulatory information.

1.1 Glossary

"Actuarial value" – The percentage of total average costs for covered benefits in a health plan.

"Affordable Care Act" – The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name Affordable Care Act (ACA) is used to refer to the final, amended version of the law.

"Appeal" – An official request from a health insurance issuer that HBE reconsider a recommendation or a decision to deny the certification or recertification of a health plan as a QHP.

"Decertify" – A decertified QHP will no longer be offered on Healthplanfinder and the QHP issuer must terminate coverage of the enrollees after providing notice and after special enrollment has been offered to the plan's enrollees (45 CFR §156.290).

"Enroll" – The point at which an individual is covered for benefits under a QHP, without regard to when the individual may have completed or filed any forms that are required to become covered by the health plan.

"Enrollee" – Qualified individual or qualified employee enrolled in a QHP.

"Expire" – When a QHP issuer does not elect to seek recertification with Healthplanfinder. This act by the QHP issuer will constitute "non-renewal of recertification" (45 CFR §156.290). The issuer's designated QHP or QHPs will expire at the end of the plan year and no longer provide coverage in the next plan year. AQHP issuer must notify the HBE before the beginning of the recertification process of their intent to let a QHP plan certification expire.

"Health Benefit Exchange Board" – The governing board of the HBE as established in Chapter 43.71 RCW.

"Health insurance issuer or issuer" – A "carrier," which includes a disability insurer, health care service contractor, or health maintenance organization, as defined in RCW 48.43.005 and defined in the Employee Retirement Income Security Act and used in the ACA.

> In this document, Issuer refers to a health insurance company, Product to a suite of plans that share, for example, a common element such as health benefits, and Health Plan as the most granule level and refers to the actual insurance coverage purchased by a consumer. The document never refers to health insurance companies as "the plans" or "the health plans."

"Health Plan" – Health plan means any policy, contract, or agreement as defined in RCW 48.43.005 and offered by an issuer and used in accordance with section 1301(b)(1) of the ACA. A health plan is the specific health benefit plan purchased by a subscriber, employer, or employee. Each health plan has a defined set of covered benefits and cost-sharing, and multiple health plans can be associated with a single product.

"Initial open enrollment period" – The initial open enrollment period offered to applicants from October 1, 2013 through March 31, 2014 to enroll in QHPs through Healthplanfinder for coverage in the 2014 plan year.

"Navigator" – An organization that has been awarded a grant by the Exchange to carry out activities and meet the standards described in §155.210. Navigator representatives are qualified, trained, and certified to engage in education, outreach and enrollment for Healthplanfinder.

"Open enrollment" – Annual open enrollment period offered by Healthplanfinder from October 15 through December 7 of the calendar year that precedes the benefit year. During open enrollment, a qualified individual may enroll in a QHP or enroll in a new QHP.

"Plan year" – The consecutive 12 month period during which a health plan provides coverage for health benefits. For Individuals, it is the calendar year, and for SHOP it is the 12-month period beginning with the qualified employer's effective date of coverage.

"Producer" – A person licensed by the OIC as an agent or solicitor to sell or service insurance policies.

"Qualified Health Plan or QHP" – A health plan that is certified by an Exchange, and is a commitment to insure essential health benefits under specific cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts) and other regulatory and contractual requirements.

"Qualified health plan issuer or QHP issuer" – A health insurance issuer provides coverage through a qualified health plan offered through Healthplanfinder.

"SHOP" – The Small Business Health Options Program operated by an Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs.

"Special enrollment" – A period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through Healthplanfinder outside of the initial or annual open enrollment periods.

1.2 Overview of Application

1.2.1 Objective

The purpose of this Application is to solicit responses from health insurance issuers to offer individual and/or SHOP QHPs through Healthplanfinder. To participate in the Exchange, a QHP issuer must meet the legal requirements of offering health insurance in Washington State.

The Application will also specify how HBE will apply the certification criteria to a health plan. To be certified, a QHP must:

- Be approved by the OIC;
- Satisfy the certification criteria adopted by the Board; and
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR Parts §155 and §156.

A QHP issuer must also sign a Participation Agreement with HBE to participate in Healthplanfinder.

1.2.2 Term of Engagement

An Individual or SHOP health insurance plan certified as a QHP will be offered through Healthplanfinder beginning October 1, 2013 with an effective date of coverage beginning no sooner than January 1, 2014.

Health insurance issuers, responding to this Application, will offer certified QHPs for a term of one year beginning January 1, 2014 and ending December 31, 2014. Only OIC-approved health plans certified by the Board may be offered as QHPs through Healthplanfinder during this period.

1.2.3 Schedule of Events

Please inform HBE of your intent to participate in Healthplanfinder. This notification of intent is voluntary and nonbinding, but will help the HBE prepare for the certification process and the initial open enrollment.

HBE is not requesting that an issuer inform HBE of the specific health plans it intends to offer through Healthplanfinder. Please, however, inform HBE of the markets, Individual and/or SHOP, in which your organization intends to offer QHPs.

Please submit your e-mail to HBE at XXXXXXXXXXXX by the date shown in Table 1: Schedule of Events.

Table 1

Schedule of Events

Event	**Due Date**
HBE releases the Application Establish website to support Application activities, e.g., Q & A, updates, information	December 3, 2012
Request written questions about the Application	December 10, 2012
Application teleconference	December 12, 2012 10:00AM – 12:00PM
Email nonbinding notification of intent to participate in Healthplanfinder	December 31, 2012
Target period to perform QHP regulatory review and certification process for QHPs	March 15, 2013 – July 31, 2013
Target date for HBE to certify QHPs	August 21, 2013
Target period for issuers to load benefit and rate data	July 1, 2013 – August 31, 2013
Target period for issuers to sign HBE Agreement	July 1, 2013 – August 31, 2013
Target date by which issuers attest to QHP benefit and rate data	September 13, 2013
Begin offering SHOP QHPs for an effective date of January 1, 2014	October 1, 2013
Offer individual QHPs through the initial open enrollment period with an initial effective date	October 1, 2013 – March 31, 2014

of January 1, 2014	

1.3 Participating in Healthplanfinder

A QHP issuer may participate in Healthplanfinder's Individual market, SHOP market, or both. An issuer is not required to participate in both markets of Healthplanfinder. An issuer, also, is not required to participate in the same markets inside and outside of Healthplanfinder.

1.3.1 Initial Certification of Qualified Health Plans

HBE intends to certify QHPs annually and only those health plans certified or recertified by HBE may be offered as QHPs through Healthplanfinder.

HBE, in partnership with the OIC, will certify the QHPs offered through Healthplanfinder. An issuer must continue to comply with OIC regulatory requirements and the OIC will continue to provide regulatory review of health insurance issuers and health plans. HBE will determine if the issuer satisfies the non-regulatory certification criteria. Once the Board issues QHP certifications, HBE will inform an issuer of the decision.

An issuer will need to enter into a Participation Agreement with HBE before offering QHPs through Healthplanfinder. The terms of the Agreement will incorporate the health plan certification criteria described in this Application, and will further identify the respective roles, responsibilities, and obligations of participating issuers and HBE. HBE reserves the sole discretion to establish, modify, and amend QHP certification and decertification criteria, terms, and conditions at any time up to and including the execution of issuer Participation Agreements.

1.3.2 Recertification of Qualified Health Plans

HBE intends to recertify a QHP annually and must complete the recertification process by the ACA deadline of September 15 of the applicable calendar year (45 CFR §155.1075(b)). The recertification process will involve a review of the certification criteria reflected in this document. HBE will notify a QHP issuer of a QHP's status at the completion of the recertification process.

1.3.3 Submitting Health Plans

The HBE certification process begins when an issuer submits a rate and form filing to the OIC for regulatory review and approval of a health plan. Please refer to the OIC for information on how and where to submit the rate and form filing for a health plan. Submitting a rate and form filing begins the regulatory review and certification process for a QHP.

SECTION II: SPECIFICATIONS FOR HEALTHPLANFINDER PARTICIPATION

2.1 Summary of Initial Certification and Recertification Criteria

To participate in HBE's QHP certification process, an issuer will need to submit plans and supporting documentation as specified for a criterion. The following chart summarizes the nineteen criteria to be applied in the certification process of a QHP. Each criterion is reviewed and approved by either the OIC or HBE.

Table 2

Summary of Initial Certification and Recertification Criteria

No.	Criteria Level	Criteria	Reviewed by OIC or HBE?	Initial Certification Criteria?	Recertification Criteria?
1	Issuer	Issuer must be in good standing	OIC	Yes	Yes
2	Issuer	Issuer must pay user fees, if QHPs assessed	HBE	Yes	Yes
3	Issuer	Issuer must comply with the risk adjustment program	HBE	Yes	Yes
4	Issuer	Issuer must comply with market rules on offering plans	OIC	Yes	Yes
5	Issuer	Issuer must comply with non-discrimination rules	OIC	Yes	Yes
6	Issuer	Issuer must be accredited by an entity that federal Health & Human Services recognizes for accreditation of health plans within the specified timeframe	HBE	Yes	Yes
7	Product	QHP must meet marketing requirements	HBE	Yes	Yes
8	Product	QHP must meet network adequacy requirements which will include essential community providers	OIC	Yes	Yes

No.	Criteria Level	Criteria	Reviewed by OIC or HBE?	Initial Certification Criteria?	Recertification Criteria?
9	Product	Issuers must submit health care provider directory data	HBE	Yes	Yes
10	Product	Issuers must implement a quality improvement strategy	HBE	Yes	Yes
11	Product	Issuers must submit health plan data to be used in a standard format for presenting health benefit plan options	HBE	Yes	No
12	Product	Issuers must implement quality and health performance measures made available to Exchange consumers	HBE	No	No
13	Product	A standard enrollment form must be used	OIC	Yes	Yes
14	Product	Hospital patient safety contracts – Contract with any hospital more than 50 beds only if it utilizes a patient safety evaluation system	OIC	Yes	Yes
15	Product	Direct Primary Care Medical Homes	OIC	Yes	Yes
16	Plan	Each QHP will comply with benefits design standards (cost sharing limits, metal level, essential health benefits)	OIC	Yes	Yes
17	Plan	Submit Exchange service area for QHP and rates for a plan year	OIC	Yes	Yes
18	Plan	Posting justifications for premium increases	HBE	No	Yes
19	Plan	Reporting data: submit and publicly disclose certain information; cost-sharing transparency	HBE	Yes	Yes

2.2 QHP Specifications

An issuer's health plan must satisfy the following criteria to become certified as a QHP offered through Healthplanfinder.

2.2.1 Licensed and Good Standing

An issuer must have unrestricted authority to write its authorized lines of business in Washington State in order to be considered "in good standing" and to offer a QHP through Healthplanfinder. The OIC is the sole source of a determination of whether an issuer is in good standing.

OIC determinations of good standing will be based on authority granted to the OIC by Title 48 RCW and Title 284 WAC. Such authority may include restricting an issuer's ability to issue new or renew existing coverage for an enrollee.

An issuer must inform HBE within five business days if the OIC has restricted in any way the issuer's authority to write any of its authorized lines of business. If the OIC has not restricted the issuer's ability to underwrite current or new health plans, then HBE will determine if the issuer can submit a health plan for certification or recertify a QHP. Restrictions on an issuer's ability to underwrite current or new health plans may result in HBE decertifying a QHP or denying recertification of a QHP.

2.2.2 User Fee Adherence

HBE has received federal grant funds to administer Healthplanfinder through 2014. The Washington State Legislature, in ESSHB 2319, directed the Board to develop a methodology to ensure HBE is self-sustaining after December 31, 2014. The Board will submit recommended funding methodologies to the Legislature by December 1, 2012.

One of those recommendations might be to direct QHP issuers to pay fees that fund the administration of HBE. If selected during the 2013 legislative session, the collection of issuer fees could begin sometime in 2014, funding the administration of HBE in 2015.

If QHP issuers are directed to begin paying such fees, then HBE must monitor the payment of those fees and take corrective action when necessary. If a QHP issuer's payment is delinquent, then HBE may assess a penalty. HBE will assess a penalty equal to 1%, rounded up to the nearest whole dollar, of the issuer's delinquent amount for each 15-day period that an issuer's payment is overdue.

If the HBE determines that a QHP issuer is not making timely and full payment of user fees, and the HBE determines that the QHP issuer will not resume making timely and full payments, then the Exchange will decertify all of the issuer's QHPs.

2.2.3 Risk Adjustment Program

A QHP issuer must comply with the requirements of the risk adjustment program as specified in the ACA, federal rules, rules adopted by the OIC, and the annual Notice of Benefit and Payment Parameters published by the Department of Health and Human Services (HHS) or the OIC.

HBE will monitor a QHP issuer's compliance with the risk adjustment program. If HBE determines that a QHP issuer is no longer complying with the requirements of the risk adjustment program, and further determines that the QHP issuer will not resume full compliance with the requirements of the risk adjustment program, then HBE will decertify all of the QHP issuer's QHPs.

2.2.4 Market Rules for Offering QHPs

An issuer must comply with the market rules for offering Individual or SHOP QHPs set forth by the ACA or Washington State law, including the four metal levels of coverage designated in §1302 of the ACA.

Please refer to OIC regulatory specifications for information on the calculation of the actuarial value for each metal level.

Only a QHP issuer that satisfies the following market rules may offer QHPs through either market in Healthplanfinder:

- A QHP issuer must offer at least one QHP at the silver level and at least one QHP at the gold level.
- An issuer must offer a child-only plan at the same level of coverage as any QHP offered through the Exchange {(45 CFR §156.200(c)(2)} to individuals who, at the start of the plan year, have not reached the age of 21.
- A health plan meeting the definition of a catastrophic plan in RCW 48.43.005 may only be sold through Healthplanfinder.

If the OIC determines that a QHP issuer is not complying with the market rules in either market within Healthplanfinder, and the OIC further determines that the QHP issuer will not resume compliance with the market rules, then the HBE will decertify all of the issuer's QHPs in that market.

2.2.5 Non-discrimination

A QHP issuer must demonstrate compliance with federal and Washington State non-discrimination requirements. A QHP issuer may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR §156.200(e)).

The OIC will enforce non-discrimination requirements and monitor for noncompliance. If the OIC determines that a QHP issuer is not complying with the non-discrimination requirements within Healthplanfinder, and the OIC further determines that the QHP issuer will not resume compliance with the non-discrimination requirements, then the HBE will decertify all of the issuer's QHPs affected by that noncompliance.

2.2.6 Accreditation

For a plan to become certified as a QHP, the QHP issuer must meet a minimum level of accreditation by an accrediting entity recognized by HHS. HBE will verify an issuer's accreditation status on the day the issuer submits a health plan(s) for certification or recertification.

For the initial QHP certification process for offering coverage in the 2014 plan year, HBE will certify a health plan as achieving accreditation if one of the following statuses is held by an issuer for commercial insurance or Medicaid products:

- NCQA: excellent, commendable, accredited, provisional, or interim (interim is a new 18-month Exchange accreditation offered by NCQA). HBE will not recognize these NCQA statuses: denied, appealed by issuer, in process, revoked, scheduled, suspended, or expired.
- URAC: full, conditional, provisional, or corrective action. HBE will not recognize this URAC status: denial.

During the initial or any subsequent certification process, HBE may certify a health plan as an unaccredited QHP if the issuer satisfies the following:

- When submitting a health plan for certification, an issuer must attest that it will schedule the "Exchange accreditation" in the plan types (HMO, MCO, POS, or PPO) used in offering its QHPs. By the end of the first plan year, the issuer must submit proof of scheduling the "Exchange accreditation."
- A QHP issuer must achieve "Exchange accreditation" and make proof of that accreditation available before the beginning of the QHPs issuer's third certification process. For example, if an unaccredited issuer began offering QHP coverage in the 2014 plan year, then it would need to achieve and document "Exchange accreditation" by the beginning of the certification process to be performed by HBE in 2016 for offering QHP coverage in the 2017 plan year.

After January 1, 2014, a QHP issuer must achieve the URAC or NCQA Exchange accreditation by the first accreditation renewal date after the QHPs issuer's third certification process.

If a QHP issuer does not maintain accreditation of a QHP as defined by HBE, then HBE must decertify that QHP.

2.2.7 Marketing

A QHP issuer will be expected to actively market products available through Healthplanfinder and to participate in joint marketing efforts with HBE. HBE has created its own logo and logo mark (or "bug") that designates the certification of a QHP. An issuer can use the Healthplanfinder bug to co-brand QHP marketing materials or web pages. The logo or bug cannot be modified, and no other logo can be used to represent Healthplanfinder or QHP certification. HBE will review and approve the use of the logo or bug on an issuer's marketing materials. The QHP issuer will be able to review any HBE marketing materials that use the QHP issuer's logo.

A QHP issuer may post one marketing document on Healthplanfinder for each QHP. In these marketing materials the QHP issuer may inform consumers that the plan is certified by HBE as a QHP. The QHP issuer cannot inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP. A QHP issuer and its officials, employees, agents and representatives must not employ marketing practices or benefit designs that may discourage the enrollment of individuals with

preexisting conditions or significant health needs in QHPs (45 CFR §156.225(b)). Marketing materials should be submitted in PDF form.

Selected issuers will be expected to create marketing and enrollment materials in advance of the October 1, 2013 open enrollment date and HBE will provide further instructions about submitting the materials.

Marketing materials will be pulled from Healthplanfinder web pages if they do not conform with the standards set through this criterion.

2.2.8 Network Adequacy

An issuer must ensure that a QHP's network satisfies at least the following standards:

- The network is sufficient in number and type of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay;
- Includes essential community providers in accordance with 45 CFR §156.235 or meets the alternate standard; and
- Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act. (45 CFR §156.230(a)).

A QHP issuer may only contract with hospitals with greater than 50 beds when the hospital utilizes a patient safety evaluation system. Hospital contracts must comply with this provision by January 1, 2015.

The OIC will enforce network adequacy requirements and monitor for noncompliance. If the OIC determines that a QHP issuer is not complying with the network adequacy requirements, and the OIC further determines that the QHP issuer will not resume compliance with the network adequacy requirements, then the HBE will decertify all of the issuer's QHPs affected by that noncompliance.

Please refer to the OIC for additional regulatory guidance on network adequacy.

2.2.9 Provider Directory

A QHP issuer must contribute data on the health care providers that participate in networks associated with a QHP. HBE will provide specifications on submitting health care provider data to prospective QHP issuers.

2.2.10 Quality Improvement Strategy

To satisfy this criterion, a QHP issuer needs to document implementation of each of the quality improvement strategies in §1311(g)(1) of the ACA:

- Improve health outcomes. The issuer must describe improvements in health outcomes through activities that include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services.

- Prevent hospital readmissions. The issuer must describe the prevention of hospital readmissions through the implementation of a comprehensive hospital discharge program. The program may include patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional.
- Improve patient safety/reduce medical errors. The issuer must describe implemented activities that improve patient safety and reduce medical errors. The activities may include the appropriate use of best clinical practices, evidence based medicine, and health information technology.
- Improve wellness and health promotion. The issuer must describe the implementation of wellness and health promotion activities.
- Reduce health disparities and health care disparities. The issuer must describe activities implemented to reduce health and health care disparities. The activities may include the use of language services, community outreach, and/or cultural competency trainings.

HBE will provide a QHP issuer with a form to submit quality improvement strategies. The submitted strategies will be posted for consumers on the Exchange web pages. If a quality improvement strategy changes, then a QHP issuer will resubmit the form with updated quality improvement strategies within thirty days.

The HBE intends to implement a quality rating system for QHPs and to publish these ratings on Exchange web pages. In order to meet this criteria, the HBE expects that a QHP issuer will need to participate in the reasonable implementation of this rating system, including the disclosure and reporting of information on health care quality and outcomes described in §1311(c)(1)(H) and §1311(c)(1)(I) of the ACA, and the implementation of appropriate enrollee satisfaction surveys consistent with §1311(c)(4) of the ACA. (45 CFR §156.200(b)(5)).

2.2.11 Standard Format for Presenting Health Benefit Plan Options

HHS will furnish the federally-established standard form for presenting health plan options. If HHS does not supply a standard form, HBE will use information from the summary of benefits and coverage.

2.2.12 Quality Measures

The criterion specifies the collection of information on QHPs, and consequently, the criterion cannot be implemented until after QHPs have offered coverage through the Exchange and quality measures have been collected.

HBE is in the process of specifying the quality measures to be collected. QHP issuers will begin collecting the quality data in the 2014 plan year. HBE will display those measures to consumers during the open enrollment period conducted in 2015 for QHP selections made for the 2016 plan year.

2.2.13 Standard Enrollment Form

The federal Department of Health and Human Services will furnish the federally-established standard enrollment form. QHP issuers will use the form and that will satisfy this criterion.

2.2.14 Hospital Patient Safety Contracts

A QHP issuer will satisfy this criterion by establishing an adequate health care provider network as specified in section 2.2.8 and further directions provided by the OIC.

2.2.15 Direct Primary Care Medical Homes

The ACA directs that a QHP may provide coverage through a qualified direct primary care medical home plan so long as the services covered by the medical home plan are coordinated with the QHP issuer. The federal rules further establish a coordination criterion to be used if a direct primary care medical home is submitted with a QHP.

State law, Chapter 48.150 RCW, however, specifies that a direct primary care medical home must be integrated with an issuer's QHP. If a QHP filing contains a direct primary care medical home, then HBE will recognize the OIC's approval of the plan to confirm that the medical home is integrated with the QHP.

2.2.16 Benefit Design Standards

A QHP issuer must ensure that each QHP complies with the benefit design standards specified in the ACA, including the cost-sharing limits, actuarial value requirements for metal levels, and the essential health benefits (45 CFR §156.200(3)).

The ACA, §1302(d), requires non-grandfathered Individual and small group health insurance plans, except for catastrophic plans, to be offered through one of four metal level categories. An actuarial value calculator, provided by the Department of Health and Human Services, can be used to produce computations of a QHP's metallic level based upon benefit design features.

Please refer to the OIC for further regulatory guidance on benefit design standards.

2.2.17 Service Areas and Rating Requirements

The QHP service area must be established without regard to racial, ethnic, language, health-status related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost, or medically-underserved populations (45 CFR §155.1055(b)). QHP service areas will be set by county and consumers will be able to identify their services area by providing a zip code or county. HBE will display the rates on the Healthplanfinder web pages. The OIC will approve that a QHP issuer set health plan rates for an entire benefit or plan year.

Approval of a plan by the OIC will confirm that a QHP has met the service area standards.

2.2.18 Posting Justifications for Premium Increases

QHP issuers are required to post justifications for specific premium increases as directed by the OIC. The OIC drafts and posts its own summary of the premium increase justification for the public. To provide information to applicants and enrollees, HBE will link to the OIC summaries on specific premium

increases. The act of linking to those summaries will satisfy this criterion for an issuer submitting a plan to become a certified QHP.

2.2.19 Reporting Data

A QHP issuer must submit, in an accurate and timely manner, to be determined by HHS, plan benefit and rate data to HBE. A QHP issuer will satisfy this criterion by submitting benefit and rate data to HBE to be used in the consumer shopping experience.

2.3 Pediatric Dental Essential Health Benefit

A QHP issuer must submit a pediatric dental benefit that is separately priced from the other benefits of the QHP. Please refer to the OIC for further guidance on setting the rate for that benefit.

2.4 Monitoring and Compliance of Qualified Health Plans

2.4.1 Summary Table 3: Monitoring and Compliance of Qualified Health Plans

The following chart summarizes the monitoring and compliance activities associated with nineteen certification criteria. Monitoring activities are applied by either the OIC or HBE. Any penalties associated with criteria #2 or #7 penalties were described in the previous section.

No.	Criteria Level	Criteria	Monitoring Entity	Penalty?	Decertification?
1	Issuer	Issuer must be in good standing	OIC	No	Yes
2	Issuer	Issuer must pay user fees, if QHPs assessed	HBE	Yes	Yes
3	Issuer	Issuer must comply with the risk adjustment program	OIC	No	Yes
4	Issuer	Issuer must comply with market rules on offering plans	OIC	No	Yes
5	Issuer	Issuer must comply with non-discrimination rules	OIC	No	Yes
6	Issuer	Issuer must be accredited by an entity that federal Health & Human Services recognizes for accreditation of health plans within specified timeframe	HBE	No	Yes
7	Product	QHP must meet marketing requirements	HBE	Yes	No

No.	Criteria Level	Criteria	Monitoring Entity	Penalty?	Decertification?
8	Product	QHP must meet network adequacy requirements which will include essential community providers	OIC	No	Yes
9	Product	Issuers must submit health care provider directory data	HBE	No	No
10	Product	Issuers must implement a quality improvement strategy	HBE	No	No
11	Product	Issuers must submit health plan data to be used in a standard format for presenting health benefit plan options	HBE	No	No
12	Product	Issuers must implement quality and health performance measures made available to Exchange consumers	HBE	No	No
13	Product	A standard enrollment form must be used	OIC	No	No
14	Product	Hospital patient safety contracts – Contract with any hospital more than 50 beds only if it utilizes a patient safety evaluation system	OIC	No	Yes
15	Product	Direct Primary Care Medical Homes	OIC	No	Yes
16	Plan	Each QHP will comply with benefits design standards (cost sharing, metal level, essential health benefits)	OIC	No	Yes
17	Plan	Submit exchange service area for QHP and rates for a plan year	OIC	No	Yes
18	Plan	Posting justifications for premium increases	OIC	No	No
19	Plan	Reporting data: submit	HBE	No	No

No.	Criteria Level	Criteria	Monitoring Entity	Penalty?	Decertification?
		and publicly disclose certain information; cost-sharing transparency			

2.4.2 Summary Table 4: Key Decisions That Alter the Offering of Enrollment in a QHP

HBE has identified key decisions by issuers, the OIC, or HBE that may close QHP enrollment or result in a QHP no longer being offered through the Exchange. The key decisions are summarized in the table below:

No.	Decision	Notice?	Open to New Enrollments?	Participate in Special Enrollments throughout Plan Year?	Decertification?	Terminate Coverage and Provide Opportunity to Enroll in Other QHPs?	Is Recertification Performed?
1	**QHP Issuer closes QHP to new enrollment**	QHP issuer informs HBE	No. New enrollees may not select the closed QHP during open enrollment However, the current enrollees may select to retain the closed QHP during open enrollment	A closed QHP must provide special enrollment for qualifying events of own enrollees A closed QHP will not participate in special enrollment for enrollees of other QHPs	No	No	Yes. The QHP must participate in and become recertified to continue offering through the Exchange
2	**QHP issuer elects not to seek recertification**	QHP issuer informs HBE at recertification	N/A	N/A	No	No. However, enrollment ends at the end of the plan year Enrollees may select a QHP, for the	No, the QHP expires

No.	Decision	Notice?	Open to New Enrollments?	Participate in Special Enrollments throughout Plan Year?	Decertification?	Terminate Coverage and Provide Opportunity to Enroll in Other QHPs?	Is Recertification Performed?
						next plan year, during open enrollment	
3	**HBE denies recertification of a QHP**	HBE notifies QHP issuer before open enrollment	N/A	N/A	No	No. However, enrollment ends at the end of the plan year Enrollees may select a different QHP, for the next plan year, during open enrollment	No
4	**QHP issuer discontinues QHP and removes QHP from the market**	QHP issuer provides 90-day notice to OIC and HBE	No	N/A	Yes	Yes. Coverage terminated only after Exchange offers special or open enrollment	No
5	**QHP issuer discontinues all plans in a market and exits that market**	QHP issuer provides 180-day notice to OIC and HBE	No	N/A	Yes	Yes. Coverage terminated only after Exchange offers special or open	No

No.	Decision	Notice?	Open to New Enrollments?	Participate in Special Enrollments throughout Plan Year?	Decertification?	Terminate Coverage and Provide Opportunity to Enroll in Other QHPs?	Is Recertification Performed?
						enrollment	
6	**OIC withdraws health plan approval and issuer removes QHP from the market**	OIC informs HBE when approval is withdrawn	N/A	N/A	Yes	Yes	N/A
7	**HBE decertifies a QHP**	HBE notifies an issuer that a QHP or QHPs are decertified.	N/A	N/A	Yes	Yes	N/A

2.5 Description of Key Decisions

2.5.1 A QHP Issuer Closes a QHP to New Enrollment

A QHP issuer must inform HBE at least fifteen calendar days before closing a QHP to new enrollment. The QHP issuer must enroll any new enrollees "in the pipeline" with effective dates after the date of closure. The Exchange will no longer offer the closed QHP during open enrollment and yet current enrollees may enroll in any other QHP during open enrollment.

A closed QHP must continue to provide special enrollment to enrollees with qualifying events. A closed QHP, however, will no longer participate in the special enrollment activities when enrollees of other QHPs experience qualifying events.

A closed QHP must continue to achieve annual recertification. If HBE denies recertification of a closed QHP, then the QHP will expire at the end of the plan year and the current enrollees may select a different QHP during open enrollment for coverage in the next plan year.

2.5.2 A QHP Issuer Elects Not to Seek Recertification and the QHP Expires

A QHP issuer must notify HBE of any QHPs that will expire prior to the beginning of the recertification process. The QHP issuer's designated QHP or QHPs will expire at the end of the plan year and no longer provide coverage in the next plan year.

AQHP issuer must notify the HBE before the beginning of the recertification process of their intent to let a QHP plan certification expire. The expiring QHP will not be offered in the next open enrollment period and the current enrollees may select a different QHP during open enrollment for coverage in the next plan year. A QHP set to expire must fulfill the obligations set forth in 45 CFR §156.290 which includes providing coverage until the end of the plan year.

Once expired, the QHP issuer may never again offer that QHP through Healthplanfinder.

2.5.3 HBE Denies Recertification of a QHP

HBE will inform a QHP issuer before the beginning of the next open enrollment period that a QHP has been denied recertification. A QHP denied recertification must fulfill the obligations set forth in §156.290 which includes providing coverage until the end of the plan year.

The denied QHP will not be offered in the next open enrollment period and the current enrollees may select a different QHP during open enrollment for coverage in the next plan year. A QHP issuer may never again offer that denied QHP through Healthplanfinder.

2.5.4 A QHP issuer Discontinues a QHP and Removes the QHP from the Market

A QHP issuer must provide formal notice to HBE that a QHP will be discontinued. The QHP issuer must provide the formal notice before enrollees receive the "90-day" notice required in RCW 48.43.035 for SHOP QHPs and RCW 48.43.038 for Individual market QHPs.

HBE must decertify the QHP and the QHP issuer must terminate coverage for the enrollees. Termination of coverage may only occur after HBE has notified the enrollees and the enrollees have had an opportunity to participate in special or open enrollment. A QHP issuer may never again offer the discontinued QHP through the Exchange.

The direction provided in this section – to perform "discontinue and special or open enrollment" for QHPs – does not change the requirements in RCW 48.43.035 and RCW 48.43.038 for issuers to perform "discontinue and replace" for plans outside of the Exchange.

2.5.5 A QHP issuer Discontinues all QHPs in a Market and Exits that Market

A QHP issuer must provide formal notice to HBE that all of the issuer's QHPs in a market will be discontinued. The QHP issuer must provide the formal notice before enrollees receive the "180-day" notice required in RCW 48.43.035 for SHOP QHPs and RCW 48.43.038 for Individual market QHPs.

HBE must decertify the QHPs and the QHP issuer must terminate coverage for the enrollees. Termination of coverage may only occur after HBE has notified the enrollees and the enrollees have had an opportunity to participate in special or open enrollment. A QHP issuer may never again offer the discontinued QHPs through the Exchange.

The direction provided in this section – to perform "discontinue and special or open enrollment" for QHPs – does not change the requirements in RCW 48.43.035 and RCW 48.43.038 for issuers to perform "discontinue and replace" for plans outside of the Exchange.

2.5.6 OIC Withdraws Plan Approval and QHP Issuer Removes QHP from the Market

The OIC will inform HBE that it must withdraw a QHP from the market.

HBE must decertify the QHPs and the QHP issuer must terminate coverage for the enrollees. Termination of coverage may only occur after HBE has notified the enrollees and the enrollees have had an opportunity to participate in special or open enrollment. A QHP issuer may never again offer the discontinued QHPs through the Exchange.

The direction provided in this section does not alter the OIC'S authority in RCW 48.18.110, RCW 48.44.020, and RCW 48.46.060 to withdraw approval of a plan.

2.5.7 HBE Decertifies a QHP

HBE may determine that a QHP no longer satisfies the certification criteria of a QHP and decertify the plan. HBE must notify a QHP issuer when a QHP is decertified.

The QHP issuer must terminate coverage for the enrollees. Termination of coverage may only occur after HBE has notified the enrollees and the enrollees have had an opportunity to participate in special or open enrollment. A QHP issuer may never again offer the discontinued QHPs through the Exchange.

SECTION III: SPECIAL GUIDANCE FOR COVERAGE OF AMERICAN INDIAN/ALASKA NATIVES

An issuer will need to comply with all federally required laws and regulations specific to American Indians and Alaska Natives (AI/AN) in the Affordable Care Act (ACA) and other federal regulations, including but not limited to:

- Monthly enrollment periods for AI/AN people to enroll in Healthplanfinder;
- AI/AN enrollee able to change from qualified heath plan to another plan one time per month;
- No cost sharing for AI/AN enrollees with incomes under three hundred (300) percent of federal poverty level;
- No cost sharing for item or service furnished through Indian Health Care Providers;
- Health programs operated by the Indian Health Care Providers will be the payer of last resort for services provided by such programs, notwithstanding any federal, state, or local law to the contrary; and,
- Compliance with Indian Health Care Improvement Act § 206 and § 408.

An issuer is encouraged to offer a contract with all Indian Health Care Providers in the issuer's service areas as in-network providers.

If an issuer contracts with an Indian Health Care Provider, the issuer will notify HBE in a timely fashion of this relationship.

SECTION IV: SHOP SPECIFICATIONS

HBE will establish a Small Business Health Options Program (SHOP). HBE will certify QHPs to be offered through SHOP and determine employer eligibility, support employee open enrollment and special enrollment, and perform premium aggregation through the billing and collection of employer premium payments. Based on federal requirements, the SHOP must:

- Offer an employee choice option (a metal level consisting of multiple plan choices).
- Offer a way for small employers to compute an estimated premium.
- Prohibit of carriers varying rates during the plan year.
- Provide electronic data to the internal revenue service (IRS) for tax administration purposes.

In addition to addressing the federal requirements, key elements of the Washington State SHOP include, but are not limited to, the following:

- Offer an employer choice option (a single plan)
- Prominent role for producers
- Employer premium contribution of at least 50% toward employees
- Employee participation requirement of 100% for employer groups with three or less employees or 75% for employer groups with more than three employees consistent with Title 48 RCW.

SECTION V: ISSUER APPEALS PROCESS

An issuer may appeal HBE's notification to the Board that a health plan will not be recommended for certification. AQHP issuer may also appeal a decision by the HBE Board to decertify a QHP.

An issuer will have up to fifteen calendar days from the date of the notification in the case of denying certification of a health plan, or a Board decision to decertify a QHP, to submit a written appeal to the Chief Executive Officer of HBE.

An issuer's appeal must:

1. Identify the specific criterion or criteria appealed;
2. Provide information that clarifies the issuer's position on each unsatisfactory criterion; and
3. Succinctly state the decision requested by the Board.

HBE must notify the issuer in writing within seven calendar days that the appeal was received. The Board will have up to thirty calendar days from receipt of the appeal to provide a written response that upholds or denies the QHP issuer's appeal.

SECTION VI: ISSUER CUSTOMER SERVICE

The HBE shall provide a Call Center to provide assistance to consumers. The HBE Call Center will receive inquiries and answer questions about health insurance eligibility, application and enrollment, including the availability of tax-credits and cost sharing reductions. The Call Center will serve customers

with a simple streamlined approach to ensure ease of use and customer satisfaction. The Call Center will provide a toll-free phone number to respond to inquiries regarding coverage offered through the HBE. The Call Center will be able to facilitate the application and enrollment process to include assistance in web-based and paper-based applications processing. The Call Center will help consumers navigate through the Medicaid Expansion program (based on Modified Adjusted Gross Income parameters: MAGI), Advanced Premium Tax Credit (APTC), Small Business Health Options Program (SHOP) and the non-subsidized uninsured seeking services related to Qualified Health Plans (QHPs). The Call Center will also triage calls concerning eligibility for other health benefit programs available to Washington State consumers, and for more complex questions, route accordingly. The HBE Call Center will be the first point of contact for many customers with questions about applying for and enrolling in health insurance through Healthplanfinder.

An issuer will also provide customer service representatives during normal business hours to assist consumers, respond to inquiries from potential enrollees, and to coordinate customer service between their own representatives, HBE, producers, and other third-party representatives.

SECTION VII: ENROLLMENT IN A QHP

7.1 Individual Enrollment Processes and Timelines

Issuers will be expected to comply with the Enrollment and Payment processes outlined in the HBE Enrollment and Payment Process Guide. Please see the guide for additional details.

7.2 Premium Aggregation

HBE will aggregate the premium contributions of subscribers enrolled in a QHP in the Individual Exchange and transmit those aggregated premium payments to the appropriate QHP issuer. HBE must also provide for a subscriber enrolled in a QHP in the Individual Exchange to pay a premium contribution directly to the QHP issuer.

HBE must aggregate premiums for a QHP offered through SHOP.

A QHP issuer must agree to comply with standards and processes established for either market by HBE for the collection and aggregation of premiums, funds transfer, reconciliation, financial accounting, and reporting.

7.3 Advanced Payment of Tax Credit Specifications

Carriers will be expected to comply with the Enrollment and Payment processes outlined in the Healthplanfinder Enrollment and Payment Process Guide. Please see the guide for additional details.

7.4 Cost Sharing Subsidy Specifications

Carriers will be expected to comply with the Enrollment and Payment processes outlined in the Healthplanfinder Enrollment and Payment Process Guide. Please see the guide for additional details.

7.5 Producers and Navigators Specifications

7.5.1 Producer

[Placeholder for possible content; may fold this content into SHOP section]

7.5.2 Navigator

HBE will award grants to Navigator organizations to carry out activities and meet the standards described in §155.210. Navigator representatives will be qualified, trained, and certified to engage in education, outreach and enrollment for Healthplanfinder. Navigators must meet conflict of interest standards and are prohibited from receiving indirect or direct compensation from a health insurance issuer based on enrollment. Health insurance issuers cannot act as Navigators.

SECTION VIII. ENROLLEE GRIEVANCE PROCESS

An issuer must notify HBE of any grievances received from enrollees. HBE will work with the issuer to resolve any serious grievances where the issuer is responsible for resolution.